GEORGIA DEPARTMENT OF COMMUNITY HEALTH

ANTICONVULSANTS PA SUMMARY

Preferred	Non-Preferred
Banzel tablets (rufinamide)*	Aptiom (eslicarbazepine)
Carbamazepine IR and ER generic	Banzel suspension (rufinamide)
Carbatrol capsules (carbamazepine SR capsules)	Carbamazepine SR capsules generic
Celontin (methsuximide)	Diazepam rectal gel generic
Depakote Sprinkles (divalproex sprinkles)	Divalproex sprinkles generic
Diastat (diazepam rectal gel)*	Felbamate generic
Divalproex DR and ERgeneric	Fycompa (perampanel)
Felbatol (felbamate)	Gabapentin solution generic
Gabapentin capsules generic	Gabapentin tablets generic
Lamotrigine tablets and chewable dispersible tablets generic	Gabitril (tiagabine)
Levetiracetam tablets and solution generic	Lamictal Kits (lamotrigine IR, ODT and XR kits)
Lyrica capsules (pregabalin)	Lamictal ODT (lamotrigine)
Onfi tablets (clobazam)*	Lamotrigine ER and ODT generic
Oxcarbazepine tablets generic	Levetiracetam ER tablets generic
Phenytoin generic	Lyrica oral solution (pregabalin)
Topiramate IR sprinkle capsules, tablets generic	Onfi oral suspension (clobazam)
Topiramate ER generic*	Oxcarbazepine suspension generic
Trileptal suspension (oxcarbazepine)	Oxtellar XR (oxcarbazepine SR)
Valproic Acid syrup generic	Potiga (ezogabine)
Vimpat oral solution, tablets (lacosamide)	Qudexy XR (topiramate ER)
Vimpat injectable (lacosamide)*	Sabril tablets and powder for solution (vigabatrin)
Zonisamide generic	Stavzor (valproic acid delayed release capsules)
	Tiagabine generic
	Trokendi XR (topiramate SR)
	Valproic Acid capsules generic

*Preferred agents that require prior authorization.

LENGTH OF AUTHORIZATION: Varies

NOTE: Criteria for Horizant and Gralise are listed in a separate document titled "Gabapentin Products".

NOTE: Brand Diastat only requires PA for members age 21 and over; generic diazepam rectal gel requires PA for members of all ages.

NOTE: If generic diazepam rectal gel is approved, the PA will be issued for brand Diastat rectal gel. If generic tiagabine is approved, the PA will be issued for brand Gabitril. If generic lamotrigine ODT is approved, the PA will be issued for brand LamictalODT. If Qudexy XR is approved, the PA will be issued for generic topiramate ER.

PA CRITERIA:

For Aptiom

- Approvable as an adjunct anticonvulsant for members with a seizure disorder (epilepsy) who have tried at least two other anticonvulsants, one of which must be oxcarbazepine.

For Banzel

- Approvable for members 1 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) when used in combination with other anticonvulsant(s).

AND

- Member must have experienced an insufficient response to at least two medications used for LGS.
- For Banzel suspension, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by the tablets.

For Carbamazepine SR (generic)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand-name Carbatrol, is not appropriate for the member.

For Diastat and Diazepam Rectal gel (generic)

- Approvable for members with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen.

AND

- Must be used for increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity. Brand Diastat is preferred; if the generic is requested, the physician should submit a written letter of medical necessity stating the reason(s) that brand-name Diastat is not appropriate.

For Divalproex Sprinkles (generic)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, the same formulation of brand-name Depakote Sprinkles, is not appropriate for the member.

For Felbamate (generic)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand-name Felbatol, is not appropriate for the member.

For Gabapentin oral solution or tablets (generic)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, gabapentin capsules, is not appropriate for the member. Otherwise, gabapentin solution is approvable for members unable to swallow solid dosage forms (or members who are less than 13) who have tried two other anticonvulsants available in liquid formulations.

For Fycompa and Gabitril (brand or generic tiagabine)

- Approvable as an adjunct anticonvulsant for members 12 years or older with a seizure disorder (epilepsy) who have tried and failed at least two other anticonvulsants.

For Lamictal ODT, Lamotrigine ODT (generic) or Lamotrigine ER (generic)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, lamotrigine tablets or chewable dispersible tablets, is not appropriate for the member. Exceptions include requests for Lamictal ODT in members with bipolar disorder unable to swallow solid dosage forms or in members with epilepsy unable to swallow who have tried and failed at least two other anticonvulsants.

For Lamictal Kits

- Physician must submit a written letter of medical necessity stating the reasons the non-kit formulation is not appropriate for the member.

For Levetiracetam ER (generic)

- Physician should submit a written letter of medical necessity stating the reason(s) the preferred product, generic immediate-release levetiracetam tablets or solution, is not appropriate for the member.

For Lyrica oral solution

- Member must be unable to swallow capsules.

For Onfi

- Approvable for members 2 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who have had an insufficient response to clonazepam and at least one other anticonvulsant used for LGS. Must be used in combination with other anticonvulsant(s).

AND

- If Onfi suspension is requested, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by administering the tablets whole or cut in half.

For Oxcarbazepine Suspension Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Trileptal Suspension, is not appropriate for the member.

For Oxtellar XR

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic oxcarbazepine, is not appropriate for the member.

For Potiga

- Approvable as an adjunct anticonvulsant for members 18 years of age or older with a seizure disorder (epilepsy) who have tried and failed at least two other anticonvulsants.

AND

- Prescriber and member must be aware of the risks of eye abnormalities characterized by pigment changes in the retina and the need for periodic eye exams.

AND

- Member must see an ophthalmologist for a baseline visual assessment.

For Sabril

- Approvable for members 1 month-2 years with infantile spasms

- Approvable as an adjunct anticonvulsant for members 10 years of age and older with refractory complex partial seizures who have tried and failed at least three other anticonvulsant medications.
- Prescriber and member must be enrolled in the Sabril SHARE program.

AND

- Prescriber and member must be aware of the risks of permanent vision loss/reduced visual acuity and the need for visual monitoring during therapy and for up to 6 months after therapy discontinuation.

AND

- Member must see an ophthalmologist for a baseline visual assessment.

For Stavzor and Valproic Acid Capsules (generic)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, divalproex DR, Depakote sprinkles, divalproex ER, or valproic acid syrup, are not appropriate for the member.

For Qudexy XR and Trokendi XR

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic topiramate immediate-release and generic topiramate extended-release, are not appropriate for the member.

For Topiramate ER generic

- Member must have experienced an insufficient response to generic topiramate immediate-release tablets or sprinkle capsules, or prescriber must submit a written letter of medical necessity stating the reasons generic topiramate immediate-release tablets and sprinkle capsules are not appropriate for the member.

For Vimpat injection

- Approvable for members 17 years of age or older with a seizure disorder (epilepsy) who have received clinical benefit from Vimpat tablets and has temporary inability to swallow or absorb the tablets. Vimpat injection must be administered in member's home by home health or in a long-term care facility.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click

on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.